DentalSelect

Protected Health Information Authorization

SECTION I. Member Information: (The individual whose information will be used or disclosed pursuant to this Authorization)

Member Name			Date of Birth	
Member ID or SSN	Group Number (if applicable)		Telephone Number	
Mailing Address		City	State	Zip Code

SECTION II. Specific Information to be Used or Disclosed: (Describe, in detail, the specific information to be disclosed to the persons/ organizations identified in Section III)

_____

_____

_____

SECTION III. Persons Authorized to Receive Information and Purpose of Disclosure:

I authorize and request Dental Select to disclose my protected health information described in Section II to the persons/ organizations identified in this Section III. I understand that if the person or organization designated by me is not a health plan or healthcare provider, the disclosed information may no longer be protected by federal health privacy laws.

Name of Persons/ Organizations Authorized to Receive the Information	Relationship to Member	Purpose of the Disclosure

SECTION IV. Expiration of Authorization:

This Authorization expires the earlier of (must choose one):

- ☐ One year from the date on which this Authorization is signed; OR
- ☐ Other (identify expiration date or "one-time release only"): _____

SECTION V. Right to Revoke Authorization:

This Authorization may be withdrawn at any time by giving written notice to Dental Select, Attn: Member Services, 5373 S Green Street, 4th Floor, Salt Lake City, Utah 84123. **Withdrawal of this Authorization will not affect any action Dental Select took in reliance on this Authorization prior to receiving written notice of withdrawal.**

SECTION VI. Signature:

In order for Dental Select to release information in accordance with this Authorization, this form must be signed by the individual, the parent or legal guardian of minor child, or the individual's personal representative.

By signing below:

I understand that this Authorization is voluntary and that Dental Select may not condition treatment, payment, enrollment, or eligibility for benefits on the signing of this Authorization. I may refuse to sign this Authorization. I may see and copy the information described on this Authorization upon my request to do so.

Dental Select and its employees are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.

Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected by the Privacy Regulations.

Signature: _____ Date: _____

Printed Name: _____ Relationship to individual: _____

IF YOU ARE SIGNING AS A POWER OF ATTORNEY, LEGAL GUARDIAN, EXECUTOR OR ADMINISTRATOR, complete the following section and attach a copy of the legal documents (such as a Power of Attorney or other relevant documents) which establish your legal authority to act on behalf of the individual listed in Section I.

Legal Representative's Signature: _____ Date: _____

Legal Representative's Name (printed): _____ Daytime telephone Number: _____

Complete, Sign and Return this Authorization to:

Dental Select, Attn: Customer Care
75 W Towne Ridge Parkway
Tower 2, Suite 500
Sandy, UT 84070

Incomplete, revoked or expired authorizations are not valid.

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